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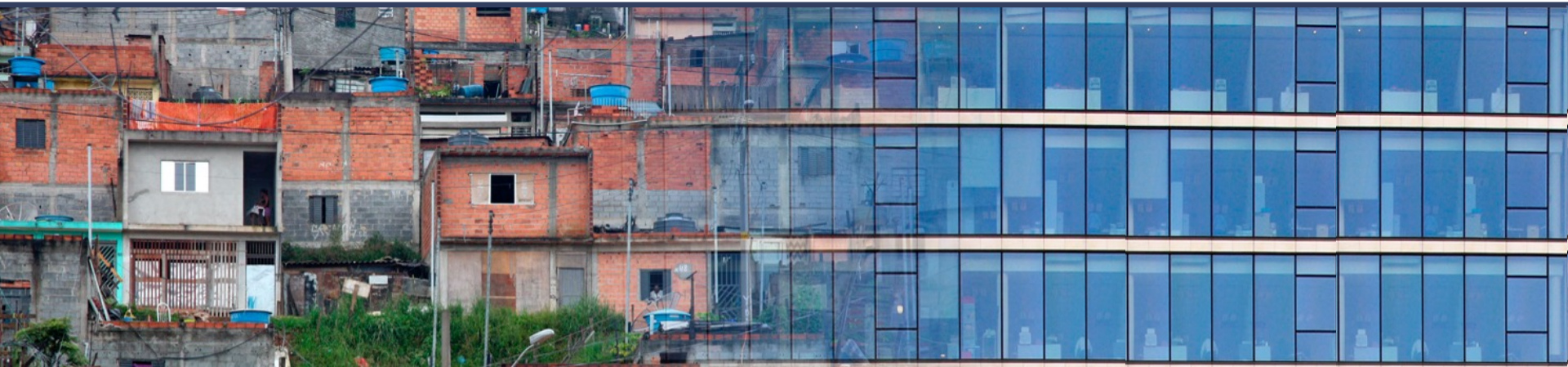
Exploring synergies between family planning (FP) and menstrual health (MH) interventions

February 2024



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Executive Summary (1/2)

- **There is a growing call for the integration of family planning (FP) and menstrual health (MH) interventions among researchers and practitioners, but very few projects have combined these two dimensions in practice**
  - Given the biological and cultural linkages between these two topics, integration should in theory improve (1) sexual and reproductive health (SRH) outcomes and (2) delivery efficiency, by piggybacking on established FP channels
  - Yet, very few projects have put this integration into practice and even fewer have documented their results, understandably so, given limited and siloed funding, as well as complex impact measurement

- **Four integrated models emerge. Assessing these on two dimensions — (1) improved effectiveness on SRH outcomes and (2) improved cost-efficiency — reveals that their potential is less straightforward than expected**
  - **(Model A) Combined education on SRH, covering both FP and MH.** This model is where the evidence is most convincing:
    - When delivered effectively, i.e., adapted to the local context and age of the target, combined education increases body literacy and agency. Yet, while education is necessary to help address FP and MH needs given the cultural taboos that hinder access to information on these topics, the impact on FP, MH, and more broadly SRH outcomes, will only materialize if services or products are available nearby and ideally benefit from additional behavior change support
    - Combined education can also be cost-efficient, i.e., these yield additional health outcomes at no (or limited) additional cost, provided there are some idle capacities among frontliner staff

Executive Summary (2/2)

- **(Model B) FP programs distributing free MH products as a way to improve SRH outcomes.** Available evidence is very scarce:
  - While few projects show that free distribution of MH products can increase FP programs' reach and trigger uptake of SRH services including FP, there is no measure of additionality of such approaches (i.e., to what extent these free products bring new menstruators to SRH services vs existing SRH users to the new program). Impact on MH indicators is dependent on initial MH product usage and quality, and is even more complex to achieve in the case of reusable MH product distribution, as the latter typically requires additional education and support for adoption
  - Cost-efficiency is uncertain, and none of the programs studied measured it. Free distribution leads to additional costs and complexity (i.e., more capabilities from frontliners in e.g., running a product stock) that improved SRH outcomes would need to balance out for this approach to be justified
- **(Model C) FP providers selling MH products commercially as added revenue opportunities.** This model has been tested more often, but as a simple "add on" as opposed to a holistic approach to improve women's SRH outcomes:
  - Interventions have in general added MH products as an additional revenue opportunity as opposed to a way to improve SRH outcomes, and as a result have not measured the effectiveness of combined sales compared to selling only one type of product
  - In theory, there is an opportunity to generate additional revenues while leveraging existing infrastructure, as products target the same clients. Yet in practice, it only works for MH products already in demand (i.e., mostly disposable pads) and/or in FP channels where prescribers have time to push new products (i.e., pharmacies and community health workers (CHWs) in rural areas)
- **(Model D) Dual-function products providing contraception while helping manage MH:** Some products under development address both objectives at once, but these solutions have not yet been tested.

Recommendation 1: Systematically integrate MH into SRH education programs and counselling

Below is a list of integration opportunities for different stakeholders involved on these topics:

- **International organizations:**
  - Integrate MH into the World Health Organization's (WHO) definition of SRH, as it was previously done for HIV, to encourage public and private authorities to systematically integrate FP and MH
- **Policymakers:**
  - Integrate MH and FP components into the SRH curriculum of schools and youth community centers, adapted to the local context and age of the targeted menstruators, and provide up-to-date referral locations for MH and FP products
- **Private and public FP clinics**:
  - Inform about contraceptive-induced menstrual changes (CIMC) leveraging for instance the NORMAL tool
  - Screen menstrual and related SRH issues (e.g., menstrual pain, menorrhagia, endometriosis) to tailor contraception recommendations
  - Provide up-to-date referral locations for MH products (if not available at the clinic)
- **Donors, development organizations, research institutions, NGOs:**
  - Consider and test further synergies while planning and funding pilots, programs and further research

Recommendation 2: Test truly integrated FP-MH approaches in holistic women health centers, leveraging synergies for improved quality of care

- Current integration of MH/ FP have had **a limited scope:**
  - The integrated models analyzed in this study have been about using MH as an **entry point** for SRH and FP discussion or just adding MH products in FP centers for **additional sales**
  - The limited funding available did not allow for more holistic approaches looking at improving overall women's health beyond FP
- Yet, results if not impressive have still been positive, and examples from adjacent fields show that a **more integrated approach around women's health could further increase outreach and impact:**
  - Combined interventions have demonstrated **benefits in terms of FP acceptability and continuation:** acceptability of FP counselling increases when MH is included, combined education/counselling helps increase body literacy and agency — likely lowering unintended pregnancies — and when women are educated about CIMCs**,** discontinuation rate of FP products appears to decrease
  - Adding broader services around women's health could **further increase outreach and impact**: while MH appears as a more acceptable entry point to discuss more sensitive FP issues, these two topics remain highly taboo. A broader scope for FP centers could in theory make them more acceptable to menstruators, especially younger, non-married menstruators, and also address their problems more holistically
  - An integrated approach also has the potential to **increase both the quality of care and cost-efficiency** of programs by boosting nurse productivity – as observed in the previous HIV-FP wave of integration
- There is an **opportunity to accelerate** the transition toward more women-centric health centers/ community health worker approaches
  - Women-centric life-stage approaches are being adopted by some FP stakeholders: as an example, MSI's strategy now covers the evolving women's needs, from menarche to menopause, in their clinic networks; Greenstar Pakistan, initially an FP provider, is developing a maternal and child health offer and PSI has launched VIYA health, its social business unit providing information, product and services on a wide range of SRH-related topics including family planning and menstrual health
  - Seizing such an opportunity will not only require additional new products and/or services, but also adapting centers' back-end (procurement, IT, infrastructure), staff capabilities and incentive schemes toward broader women health outcomes, as well as ensuring that funders' KPIs align with these redefined objectives

Recommendation 3: Conduct more systematic impact assessment of integrated programs to confirm impact of various integrated models (1/2)

	Model A: Combined education programs	Model B/C : Combined distribution programs (free or commercial)

Impact potential	▪ Does combined FP and MH education result in better understanding of fertility and SRH issues?
	▪ Does the intention of using FP/other SRH services translate into effective service uptake and continuation?
	▪ How does greater knowledge translate into long-term changes in behavior and attitudes for FP and MH, i.e.,
	  ▪ How many menstruators report being satisfied with their ability to manage their menstruation?
	  ▪ How many menstruators report that menstruation no longer impacts their day?
	  ▪ How many menstruators report being satisfied with their current contraceptive use?
	  ▪ How do outcomes compare to standalone education programs with similar objectives or control groups?
		▪ Impact on FP and SRH
		  ▪ Does offering MH products increase the uptake and continuation of FP products/ other SRH services?
		  ▪ Does it increase the number of menstruators reporting that they are satisfied with their current contraceptive use?
		  ▪ Does MH product distribution bring new menstruators to FP centers?
		  ▪ Does offering a choice of different MH products increase uptake of FP/other SRH services and continuation to FP products compared to only one type of MH product?
		▪ Impact on MH
		  ▪ Are FP points of distribution preferred by menstruators compared to existing alternatives like retail stores?
		  ▪ Does offering MH products increase the number of menstruators being satisfied with their ability to manage their menstruation?
		  ▪ Do menstruators continue to use the free MH products provided in the long term?
		  ▪ Does offering a choice of different MH products increase uptake and continuous use of MH products? How much do reusable products represent in terms of uptake compared to disposable solutions?
		  ▪ How do outcomes compare with control groups / alternative approaches?

NB: this list of questions is not exhaustive

Recommendation 3: Conduct more systematic impact assessment of integrated programs to confirm the cost efficiency of various integrated models (2/2)

	Model A: Combined education programs	Model B/C: Combined distribution programs (free or commercial)
Cost efficiency	▪ What is the total cost of integrated education programs when delivered at scale? ▪ How does it compare to individual approaches targeting MH or FP? ▪ Do additional outcomes offset the added costs?	▪ Does it increase or decrease staff effectiveness in delivering initial SRH services? ▪ In case of free distribution, what is the total cost of these programs when delivered at scale? ▪ In case of commercial sales, how much additional revenue can an FP provider with idle time generate through the sales of MH products? Is this profitable for FP providers? ▪ How does it compare with individual approaches targeting MH or FP? ▪ Do additional outcomes offset the added costs? ▪ Which levers maximize cost-efficiency (i.e., level of training, type of training, i.e., individual vs groups, incentive types, pre-existing usage of MH products)?

NB: this list of questions is not exhaustive

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Family planning and menstrual health both contribute to good sexual and reproductive health

Sexual and reproductive health[1] (SRH) : "*Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to do so. To maintain one's sexual and reproductive health, people need access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections*"

Family Planning[2] (FP): *Family planning allows people to attain their desired number of children, if any, and to determine the spacing of their pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility.*

Menstrual Health (MH): *MH is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in relation to the menstrual cycle.[3]*

Menstruation is a natural and essential part of the reproductive cycle. MH is an integral part of sexual and reproductive health and rights. MH is critical for the health, well-being, mobility, education, economic empowerment, and dignity of women, girls and people who menstruate.[4]

Source: [1] *Sexual & reproductive health*, UNFPA (2023); [2] *Contraception*, WHO (2023); [3] *Menstrual health: a definition for policy, practice, and research*, Hennegan et al. (2021); [4] The integration of menstrual health into sexual and reproductive health and rights policies and programmes, UNFPA (2021)

Researchers, practitioners and funders are calling for greater integration of FP and MH interventions within SRH

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In the past 5 years, various actors from the FP and MH sectors have started calling for combined interventions[1]

WaterAid · psi · FSG REIMAGINING SOCIAL CHANGE · Global Menstrual Collective · THE CASE FOR HER · fhi360 · UNFPA

A **few examples of key reports and statements include**:

- FSG's 2020 report on interlinkages between menstrual hygiene and health, wellbeing, empowerment, education
- The Global Menstrual Collective's 2023 report on integrating MH and SRH as a pathway for gender equality
- Research articles underlining the synergies between MH and FP and opportunities for integration by leading researchers like *Missed Opportunities: Menstruation Matters for Family Planning* (Hennegan, Tsui and Sommer, 2019) or *Seeking synergies: understanding the evidence that links menstrual health and sexual and reproductive health and rights* (Wilson et al., 2021)
- Technical briefs presenting how to integrate MH into broader SRH, including FP, such as by UNFPA and WaterAid or by PSI

This is partly inspired by previous waves of integration like HIV & SRH[2]

World Health Organization

- The **promotion of HIV & SRH integration has been pushed for decades and** is **included in the WHO's recommendations** on sexual health (unlike MH, which is not explicitly mentioned): *"Sexual health-related issues are wide-ranging, and encompass sexual orientation and gender identity, sexual expression, relationships, and pleasure. They also include negative consequences or conditions such as infections with human immunodeficiency virus (HIV)"*
- *According to the WHO, while there is limited data* on the extent to which HIV testing services have been integrated into family planning services, the **limited evidence shows positive outcomes on access, quality of care and nurse productivity**, while reducing stigma, without compromising uptake of care[3]

Source: [1] *FSG's 2020 report*, *Addressing the gap: Integrating menstrual health into the broader SRHR discussion*, Lucy Wilson (2019); *The Power of Integration*, Global Menstrual Collective (2023); *Missed Opportunities: Menstruation Matters for Family Planning*, (Hennegan, Tsui and Sommer, 2019), *Seeking synergies: understanding the evidence that links menstrual health and sexual and reproductive health and rights* (Wilson et al., 2021) *Inclusion of menstrual health in sexual and reproductive health and rights*, Philips-Howard et al. (2018); *The Intersections Between Contraception & Menstrual Health: An Annotated Bibliography*, FHI360 (2021); *Technical brief for the Integration of Menstrual Health in SRHR*, PSI and The Case for HER (2019); *Integrating Menstrual Health and Sexual and Reproductive Health and Rights*, UNFPA and WaterAid (2022; [2] *Sexual health*, WHO (2023), [3] *Integrating Sexual and Reproductive Health Services Within HIV Services: WHO Guidance*, Ford et. al (2021)

Offering services together should theoretically help improve several health outcomes

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MH and FP often impact each other, making the case for holistic offers and integration

- **A better understanding of contraceptive-induced menstrual changes** (CIMCs) can lead to **higher FP uptake and continuation**
  - More than half of menstruators who stop using a contraceptive in LMICs do so for method-related reasons (e.g., side effects, health concerns) [1]
  - CIMCs are the first cause of method-related contraceptive discontinuation[1]
  - Indeed, some women perceive CIMCs as responsible for many health concerns e.g., absence of menstruation causing a build-up of "dirty", "blocked" blood, blood clots, emotional disturbances, infertility or death[2]
- **Using FP products** (e.g., contraceptive pills) can help reduce menstrual pain
- **Access to MH products and FP products that reduce the menstrual flow** (e.g., hormonal IUDs) can help **better manage heavy bleeding** (and indirectly, reduce related anaemia)
  - Heavy bleeding, “menorrhagia”, affects 10 - 30% of menstruators globally[1]
  - Anaemia, impacting up to two-thirds of menstruators with menorrhagia is a major contributor of maternal and perinatal morbidity (e.g., anaemia is responsible for 18% of perinatal mortality in LMICs)[2]

Beyond FP, a better access to MH can also help improve other SRH outcomes

- **Using purpose-made MH products** can help **reduce reproductive tract infections** (RTIs) and risks of infertility[1]:
  - Research suggests that, despite limited data availability, poor MH could cause RTIs (e.g., bacterial vaginosis)
  - These RTIs make pre-term birth more likely and may increase susceptibility to HIV infection
- A study in rural Kenya showed that the free provision of menstrual products can reduce the incidence of **STIs arising from transactional sex** (4.2% in the group using pads and cups, 4.5% in the group using pads, vs 7.7% in the control group)[4]
- A **more comprehensive delivery of care and screening** (enabled by integrating FP and MH) can help **better identify and treat early signs of SRH issues,** such as endometriosis (which affect 2 to 17% of menstruators globally)[1]

Source: [1] *Seeking synergies: understanding the evidence that links menstrual health and sexual and reproductive health and rights*, Wilson et al. (2021); [2] *There might be blood: a scoping review on women's responses to contraceptive-induced menstrual bleeding changes*, Polis et al. (2019); [3] *Maternal anemia and risk of adverse birth and health outcomes in low- and middle-income countries: systematic review and meta-analysis*, Rahman et al. (2016); [4] *Menstrual cups and sanitary pads to reduce school attrition, and sexually transmitted and reproductive tract infections: a cluster randomised controlled feasibility study in rural Western Kenya*, *Phillips-Howard PA, Nyothach E, ter Kuile FO, et al (2016)*

From a cost-efficiency perspective, piggybacking on established FP channels could help scale up MH access

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Family planning is a more advanced and funded topic that could be leveraged to push MH progresses[1]

	Family planning	Menstrual health
Current users in the Global South	**Up to 68%** of women of reproductive age use modern FP[1]	**Only 35-50%** of menstruators use commercial products to manage their menstruation[2]
Current and projected investment in the sector	Donors are **projected to provide $8.6 billion** between 2020 and 2030[1]	▪ **MHH is not prioritized** by donors, governments or implementors ▪ **Sector actors deem funding marginal today** and do not expect it to be sufficient in the coming years[3]

There is an **opportunity to piggyback on these FP investments** to develop the overlooked MH sector

FP channels appear to be good gateways for MH product distribution[4]

- It is **more feasible to add MH products to an FP portfolio** rather than the opposite:
  - **FP products require medical counselling** to avoid contraindications vs. MH products can be freely chosen by menstruators depending on personal preferences*
  - **Sales of FP products require official authorizations** (as medical products) vs. MH products are considered either fast-moving consumer or pharmaceutical goods
- **Practitioners are looking to become more women-centric**, going beyond traditional activities focused on providing FP and abortion services to deliver more holistic services:

RAHNUMA

For Dr Anjum Rizvithe, Director of Programs at the Rahnuma Family Planning Association of Pakistan, it would allow to "*get all services under one roof, answering the needs of girls and not only mothers*"

MSI REPRODUCTIVE CHOICES

MSI Reproductive Choices (MSI) stated goal is to cover the evolving women's needs, from menarche to menopause, in their clinic networks

FPA India Family Planning Association of India

The Family Planning Association of India, the largest FP organization in the country, started with a focus on FP but has now extended its scope to all SRH topics - including MH

Source: [1] *Cost of Ending Unmet Need For Family Planning*, UNFPA (2020); [2] *Scaling Up Access to Menstrual Health in the Global South: Improving product quality and access to reusable options*, Hystra (2023); [3] *Making the case for investing in menstrual health & hygiene*, PSI, The Case for Her, WASH United, the Global Menstrual Collective (2021); [4] Interviews with mentioned organizations (2023)
*Caveat: there are some counter indications for menstrual cup when using an IUD

Yet, very few projects have effectively integrated these two dimensions…

Hystra's research identified around 30 projects integrating these two dimensions in the Global South[1]

Model	*Description*	*# of projects*
A	**Combined education on both FP and MH**	17
B	**FP programs distributing free MH products**	3
C	**FP providers selling MH products commercially**	10
D	**Dual-function products**	1 under dev.

The limited number of projects is in part due to siloed programming and a lack of proof of concept to develop new ones

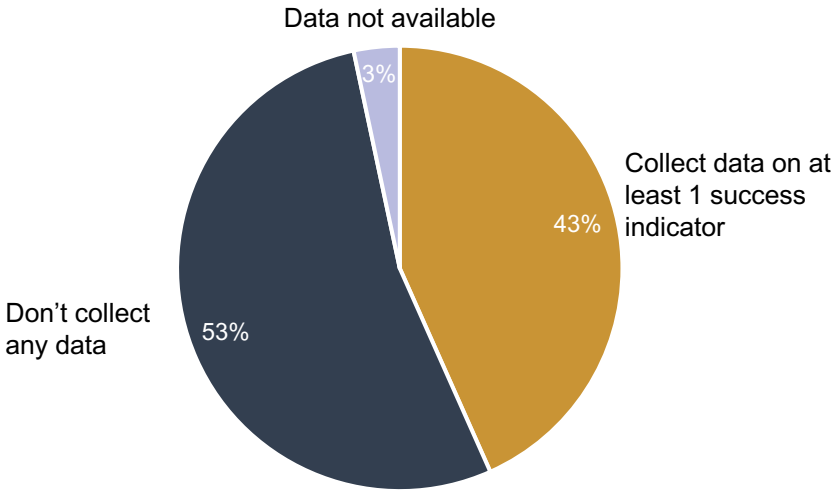
- **Donors have traditionally focused on FP**, potentially because measuring its impact is easier (through the Couple-Years of Protection, CYP) compared to MH – which does not have a single impact KPI
- **Operational complexities related to the different nature of value chains (medical vs FMCG)** limit synergies both upstream (not the same manufacturers) and downstream (traditionally not the same sales and distribution channels), further complexifying integration
- **Purely procedural limits can hinder combined delivery of FP and MH in public or donors' programs** (e.g., unconnected interventions do not allow a patient to receive both FP services and MH products at once due to user record problems)
- **The lack of past programs creates a vicious circle:** the lack of data to assess impact potential and analyse cost/benefit ratios makes it difficult to convince donors to fund new ones. The focus on cost-efficiency also implies that they often prioritize maximizing service delivery targets (e.g., CYP) over the testing of new approaches
- **The few projects that have collected impact data have limited samples to draw statistically-significant evidence**, and the short evaluation timelines prevent long-term impact measurement

[1] The GAP project led by MSI and Water Aid is counted in model A and C because of the programs' different activities

Source: Extensive literature review (90+ documents) and 30+ interviews with expert and practitioners; NIRAPOD End-line Evaluation Report, Human Development Research Centre (2020); *Access to menstrual hygiene products through incentivised, community-based, peer-led sexual and reproductive health services before and during the COVID-19 pandemic: findings from the Yathu Yathu trial*, Hensen et al. (2022)

… and even fewer have documented their results

Only 43% of projects collect indicators (N = 30)



- Only 1 project collected information on long-term indicators such as FP continuation
- Only 4 projects collected data on MH management satisfaction
- The highest data collection rate was in model B* (100%, n = 3), followed by model A* (47%, n = 17). Model C* had a very low data collection rate of just 30% (n = 10).

Note*: Model A – Combined education on both FP and MH; Model B – FP programs distributing free MH products; Model C – FP providers selling MH products commercially

We have assessed these models on two criteria to identify the most promising ones to test further

A	Combined education on both FP and MH
B	FP programs distributing free MH products
C	FP providers selling MH products commercially
D	Dual-function products

Improved effectiveness on SRH outcomes

Do combined programs lead to better SRH outcomes, compared to doing separate ones?

Improved cost-efficiency?

Do combined programs lead to less spend per impact achieved?

The list of projects analysed is based on data voluntarily shared by organizations through secondary data and interviews.

➔ *Details on projects studied under each model are available in the appendix*

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This research is based on existing research and projects, complemented with expert insights

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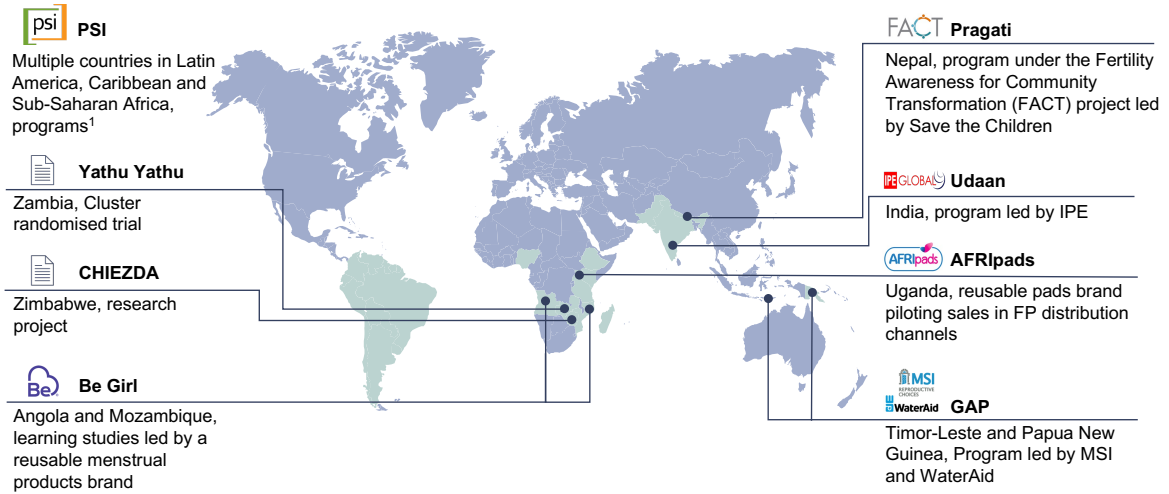
This research is based on an extensive literature review and interviews

- We reviewed **90+ documents:** research papers, technical briefs, project briefs and evaluation reports,
- We conducted **interviews with 30+ experts of the sector** (researchers, practitioners, funders) gathering their insights and experience and testing our hypotheses with them

We have leveraged the learnings from eight flagships projects that combine MH and FP interventions



[1] For clarity purposes, these countries are highlighted in green on the map but not pointed at

For more details on the methodology, please see appendix

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Overall, the potential of integrating FP and MH is not as straightforward as expected, and little documented

Model	*Description*	*Improved effectiveness for FP/SRH outcomes*	*Improved effectiveness for MH outcomes*	*Cost-efficiency*
A	**Combined education on both FP and MH**	Effective but not sufficient to sustain long term behavior change	Effective, provided products are available	Yes, provided there are some idle capacities
B	**FP programs distributing free MH products**	Increases program reach and uptake but no measure of additionality	Depends on initial MH product usage and quality	?
C	**FP providers selling MH products commercially**	?	?	Yes, for products already in demand
D	**Dual-function products**	?	?	?

Source: Hystra analysis. Harvey balls were determined based on the number of projects in each model, data available on them (and its quality), scale of projects, level of confidence in their assessments and attached results.

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Model A – Combined education on both FP and MH

Description

Adding FP to MH education programs and vice versa

Such education programs include trainings in schools or within communities, mobile apps covering SRH topics, counselling from family planning providers or community health workers (CHWs)

Improved effectiveness potential on health outcomes?

Combined education programs are **effective in increasing body literacy and agency,** in turn helping **lower unintended pregnancies** and help **address FP and other SRH needs** (see details on p.23-27)

Improved cost-efficiency?

Combined education programs **can also be cost-efficient**, provided there are some **idle capacities** and menstrual products and FP services are **available nearby** (see details on p.28-29)

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Integrated education programs including both FP and MH address an unmet need and increase program acceptability

Integrated education programs have shown to answer an unmet demand from beneficiaries to better understand their bodies

- **Practitioners consistently report questions** about the links between menstruation, pregnancy and FP:

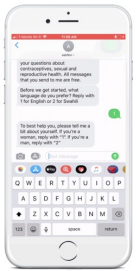
Dr Anjum Rizvi

Director of Programs at Rahnuma Family Planning Association of Pakistan: "*The need for more MH is very high, girls really want information and access to commodities*"[1]

Leisa Hirtz

Founder and CEO of Bfree: "*We teach on the entire menstrual cycle with emphasis on the fertile days related to ovulation. With adolescent girls and boys, this invariably raises questions around pregnancy prevention and FP*"[2]

- Connecting the two **increases engagement:**



After integrating MH into its social media posts providing education on SRH, PSI Central America saw an **increased engagement rate* on posts related to MH (20%)** compared to FP (3%)[3]

Nivi, deploys a chatbot using AI to provide education, referral, and post-service follow-up on multiple health topics. While MH has not yet been a partner-supported health journey, Nivi has received a lot of engagement on MH, showing the high organic interest from Nivi users for this topic. 11,5% of users access both FP and MHH journeys on the platform (while partner-supported FP campaigns draw users to the Nivi chatbot, the freely available MH content is spontaneously accessed by interested Nivi users)[4]

Adding MH in FP education is an efficient conversation starter and increases acceptability of counselling

A study on women's preferences around FP in Kenya showed that **54% of them do not feel comfortable with family planning providers** - highlighting the need to **ease and create trust** within these relationships[5] – which might be facilitated by starting discussions with menstrual health topics

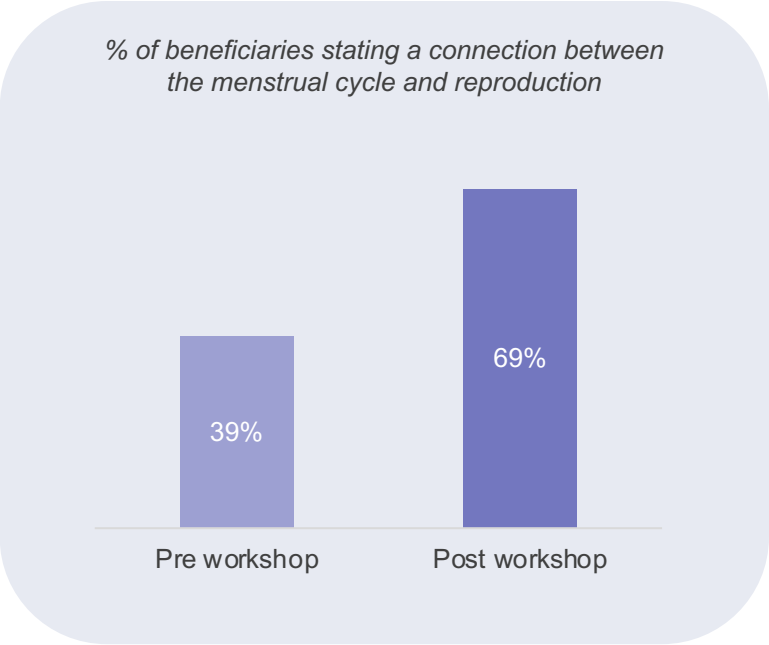
PSI Pakistan noticed that integrating MH into community sensitization on FP **eased conversations on two levels**[6]:

1. **Sparking discussions between mothers and daughters**, who rarely discuss these topics together
2. **Generating greater trust within the community,** helping other community members (especially men) perceive the program as education for women's health in general, and not as an incentive to have fewer children

* Engagement rate is a measure of how much of the audience actively engages with content on social media. Common metrics are clicks, likes, reactions, comments, shares or message.

Source: [1] Interview with Rahnuma Family Planning Association of Pakistan (2023); [2] Interview with Bfree (2023); [3] *Technical brief for the Integration of Menstrual Health in SRHR*, PSI (2019); [4] Interview with Nivi (2023); [5] PMA Module on Self-Care in Family Planning: Results from Kenya, Research for Scalable Solutions (2021); [6] Interview with PSI Pakistan (2023); Photo credits: Bottom left: Nivi website; Right: PSI Pakistan

Integrated education programs seem effective in increasing beneficiaries' body literacy and SRH understanding…



Research conducted in Angola by Be Girl[1] showed that attending a **series of educational workshops** on MH helped beneficiaries **better understand fertility and reproduction**

Source: [1] *Menstrual Management in Angola: Effectiveness of providing quality menstrual products and educational workshops in Huambo, Huila, Luanda, and Lunda Sul*, Be Girl (2021);

… but need to account for contextual factors (culture, age) to maximize impact

Education programs need to adapt their content to age to ensure acceptability in local communities while maximizing impact[1]

- Guidelines from UNESCO[2] detail topics to cover **depending on areas of integration** (e.g., education, counselling) and **age** (e.g., adolescents, menopause)
- Some recommendations are **common across all life stages**:
  - Providing **evidence-based general education** on fertility, MH and FP
  - Giving **access to tools** to further advance this education, e.g., digital channels like AskNivi
  - **Train CHWs** to deliver the right information in a sensitive way
- However, some topics and ways to approach education **differ**:
  - For adolescents, counselling and education should **be age-appropriate and youth-responsive**, and support should be provided to stakeholders interacting with them to further deliver or complement this education
  - During mid-life and reproductive years, counselling and education should **address postpartum return to fertility**
  - During perimenopause and menopause, counselling and education should discuss these topics specifically

Content should also be adapted to the cultural context and involve key stakeholders to ensure buy-in[3]

- Parents and government officials are usually reluctant to discuss FP and the challenge of teenage pregnancies with adolescents, as explained by Prof. Penelope Philips-Howard, a public health epidemiologist specialized in MH and SRH: *"Parents and teachers are conflicted about giving FP to girls by fear of encouraging sexual intercourses"*
- An example of a program that has adapted its programs is **WaterAid** which led the HerWASH program (focused on MHH, but with integration of SRH topics into the training) :
  - They made sure to get buy-in from traditional, cultural, and religious leaders to ensure uptake and attendance of the project initiatives
  - This led religious leaders to open their spaces for community sensitization sessions

Source: [1] *Strengthening Integrated Approaches for Family Planning and Menstrual Health*, Hoppes et al. (2023); [2] International Technical Guidance on Sexuality Education: An Evidence-Informed Approach. UNESCO; 2018 [3] Interviews with Prof. Penelope Philips-Howard, MS Bangladesh and WaterAid (2023);

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By increasing body literacy, combined education programs help address FP and SRH needs

A greater body literacy and understanding of SRH…

…lowers unintended pregnancy

A cross-sectional study in 29 African countries indicates a **strong association** between **incorrect knowledge of ovulation** and **unintentional pregnancy**[1]

…helps address FP needs

- The Pragati study, which organized community level games to spark conversations around fertility, MH, and FP in Nepal had **a positive impact on FP outcomes**[2]:
  - Increasing FP uptake from **31% to 35%** in the community
  - Individuals with a high fertility awareness score had **1.7 times more chances of using an FP method**

… can lead to reduced discontinuation of FP products thanks to a better understanding of CIMCs

The Udaan project led by IPE had a call centre to contact first time injectable contraceptive users: they saw that **FP continuation increased from 65% to 80%** for injectables when menstruators were called back to discuss contraceptive-induced menstrual changes (CIMCs) [3]

FHI 360 and PSI developed the "**NORMAL" tool*** that helps deliver **key information on CIMCs** through six key messages: CIMCs are **N**ormal, can provide **O**pportunities in personal life, menstruations will **R**eturn, CIMCs can come from different **M**ethods, **A**bsence of menstruation can be normal, there are options if these changes **L**imit daily activities

*For the detailed tool, see: *NORMAL Counseling Tool for Menstrual Bleeding Changes*, FHI 360 (2019)

Source: [1] *Fertility knowledge, contraceptive use and unintentional pregnancy in 29 African countries: a cross-sectional study*, Iyanda et al. (2020); [2] *A Participatory Fertility Awareness Intervention to Increase Family Planning Acceptability and Use*, FACT (2019) ; [3] Interview with IPE (2023)

Yet, while education is a necessary first step to access FP and other SRH services, it is often not sufficient to trigger behaviour change

- **The impact of education on FP and SRH outcomes is not necessarily immediate:** menstruators can integrate knowledge on FP options and SRH in general, but decide not to use any because of their **age or marital status.** Based on the experience of Girl Effect, even if the intention to change behaviors after receiving awareness can be high, **it takes up to two years to change a complex behavior** (e.g., those associated with gender norms, usually deeply rooted)
- **In addition, while knowledge is a necessary first step to access FP and other SRH services**, **other components impact behavior change:** as explained by Karina Rios Michel, Chief Creative & Technology Officer at Girl Effect, "*The strongest indicator if a girl will uptake a service is if it feels relevant and they identify with the behavior of accessing it. We have found that we can educate someone but knowledge alone doesn't necessarily translate into action.*" [1]
- **Adolescents, in particular, face several barriers when trying to access FP and SRH services**, even when educated, such as stigma, the need for parental authorization, and the lack of financial means. Girl Effect theorized that, beyond knowledge, **there are seven other drivers** that programs can leverage to help shift behaviours[2]:

Knowledge around the behaviour

+

Self-identity
How menstruators see themselves

Social identity
The reference group menstruators compare to

Outcome expectation
Perceived risks and benefits of adopting a behaviour

Perceived social support
Support from people about performing a behaviour

Self-efficacy
Self-confidence in the ability to perform a behaviour

Perceived control
Level of difficulty of performing a behaviour due to external barriers (e.g., availability)

Attitude
Perception on a behaviour (e.g., good or not, important or not)

Source: [1] Interview with Girl Effect (2023); [2] Girls and mobile report, Girl Effect (2023)

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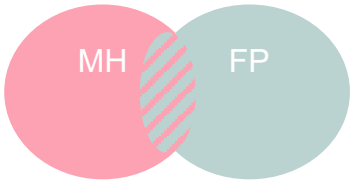
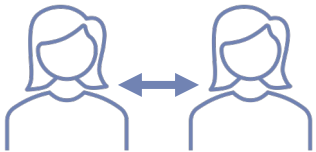
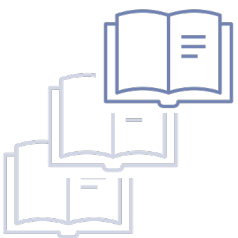
Additional costs are limited as combined programs can leverage existing infrastructure and resources



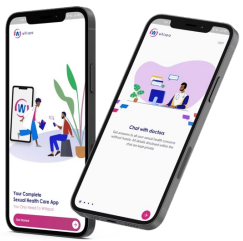
There are no additional outreach costs as MH and FP target the same population of menstruators - the complementary outreach of current MH and FP programs (respectively primarily adolescents and married women) could even help better reach all menstruators



Beyond the curriculum, leveraging existing trainers is another opportunity to reduce costs: ChildFund India uses young "peer educators" (each of them training 8 to 10 other adolescents on SRH) whose **training costs only $5** (including a 3-day initial trainings)[3].



Costs to provide combined education range from $2-3[1] to $17[2] per person depending on the project* (including costs incurred in using a human-centered design approach to design and pilot interventions), with one of the most **expensive components being the design of the curriculum** (approx. 30%[1] of the costs). Now that several integrated programs exist, there is an opportunity to leverage existing curricula to minimize costs



Digital platforms (e.g., WHISPA Health; Honey & Banana, Nivi, Girl Effect) could help reach menstruators at scale: **90% of Kenyan women** would be interested in **receiving FP information on their phones** (and 56% on social media)[4]

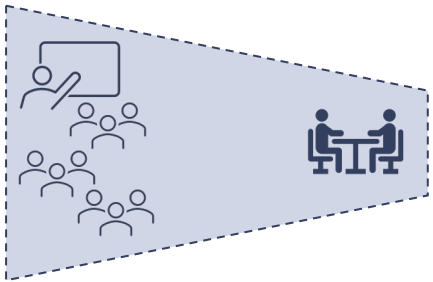
Source: [1] BeGirl interview (2023); [2] Effects of Udaan intervention to prevent teenage pregnancy in Rajasthan: Findings from a multi-component evaluation (Population council, 2022); [3] Interview with ChildFund India (2023); [4] PMA Kenya (2022); Photo credits: whispa website

* Costs per person were calculated by dividing total cost of BeGirl and Udaan interventions by the number of people reached

Implementation success depends on the availability of products nearby and time available from frontliners

To effectively **convert improved knowledge into behavior change**, a **portfolio of products** including both FP and MH must be available, as well as **FP and SRH services nearby:**

- Living Goods saw that that **specific referrals** with a date and time to get FP services work much better than generic advice: 25% of pregnancy care users and 50% of FP users accessed a service within a month after receiving a specific referral[1]
- Research in Uganda showed that encouraging women to visit specific FP facilities via text messages leads to 75% of them visiting the referred facility[2]
- The unavailability of products can **negatively impact the "perceived control"** theorized by Girl Effect (i.e. the level of difficulty perceived about performing a behavior), becoming a **barrier to new habits**[3]



Cost-efficiency also depends **on frontliners' available time and motivation** to include MH:

- In the GAP project (that conducted combined distribution and education on MH and FP), the MSI staff considered some MH activities out of their scope (since not directly linked with FP), and faced issues **prioritizing their work**[4]
- To minimize the time needed from resource-constrained staff, the Udaan project **used a funnel approach**, leveraging group sessions to deliver key messages before the individual counselling sessions[5]

Source: [1] Interviews with Living Goods (2023); [2] Can Mobile Phone Text Messaging Increase Uptake of Family Planning Services in Uganda? Betty Walakira et al (2013) [3] *Girls and mobile report*, Girl Effect (2023);[4] *Keeping Girls in School Through Improved Reproductive and Menstrual Health - Gap Endline Evaluation*, Karen Hobday (2021); [5] Interview with IPE (2023)

Model A

Opportunities for exploration: **Advocate for combined education, including information on products, where and how to access them**

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1 Advocate to the WHO and public authorities

As for SRH & HIV, **integrating MH into SRH definition from the WHO would encourage public authorities to take concrete measures to integrate both topics** in various places:

- **For adolescents**: Integrate MH and FP components into the SRH curriculum in schools and youth community centers, based on the local context and age of the targeted menstruators, and provide up-to-date referral locations for MH and FP products
- **For adult menstruators**: Inform about CIMCs (leveraging for instance the NORMAL tool), screen menstrual and related SRH issues (e.g., menstrual pain, menorrhagia, endometriosis) to adapt contraceptive recommendations and provide up-to-date referral locations for MH products (if not available at clinic)

2 Measure long-term outcomes

When investing in education programs, whenever possible, measure not only the impact on understanding of SRH issues but also the uptake and continuation rate of FP and other SRH services to quantify long-term impact and allow comparisons between programs:

- Does the intention of using FP and other SRH services translate into effective service uptake and continuation? How does it compare with other programs with similar uptake objectives?
- How do these programs impact gender norms?
- How does the understanding of fertility and menstrual health sustain over time?
- How does this greater knowledge translate into changes in behavior and attitudes in the long term for FP and MH, i.e.,
  - How many menstruators report being satisfied with their ability to manage their menstruation?
  - How many menstruators report that menstruation no longer impacts their day?
  - How many menstruators report being satisfied with their current contraceptive use?
- How does this compare to standalone education programs with similar objectives or control groups?

3 Ensure programs refer to places selling MH and FP products, possibly leveraging digital tools

To translate education into action and uptake of products, ensure various FP and MH products are mentioned[1] and associated with sales channels where they can be purchased, including via online channels :

- **For MH products[1] (and some FP products)**: E-commerce websites (Sirona, Kasha) can effectively distribute these products across country, especially reusable MH products that are less known and available locally
- **For FP services**: Educational material can provide geo-localized FP centers or numbers to ensure effective referrals, on top of traditional referrals to clinics
- **For norms shifting in the longer term:** Use platforms and content that adolescent girls can identify with to work in the long-term on gender biases and taboos

Source: Hystra analysis; [1] For MH products, see Managing Menstruation: Know Your Options, from Reproductive Health Supplies Coalition

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Model B – FP programs distributing free MH products

Description

Distributing free MH products (disposable and reusable) **and conducting MH education on top of existing FP programs,** in order to improve overall SRH outcomes

Improved effectiveness potential on health outcomes?

The **scarce evidence** available shows that free distribution of MH products seems to increase FP programs' reach and **trigger FP and other SRH service uptake***.
Impact on **MH indicators** is **dependent** on initial MH product usage, material quality and level of support provided for reusable products (see details on p.33-34).

Improved cost-efficiency?

Free distribution leads to **additional complexity and costs**, that **improved SRH outcomes** need to **balance out** (see details on p.35).

*Nb: the question related to ensuring that menstruators do not feel compelled to use FP products to access free MH products has not been explored in the reports studied and should be explored further.

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The scarce evidence available shows that free distribution of MH products can increase programs' reach and trigger FP uptake

Distribution of free MH products can help attract menstruators into SRH programs

- In the CHIEDZA program, which set up centers combining MH and FP services, **almost all (**86.7%) **female participants cited MHH as their first reason behind their initial visit**. Client interviews showed that the popularity of the MH services made the program look less focused on SRH, which eased visits - especially for young women[1]

- The Yathu Yathu program, which offered MH and FP services with a reward system allowing to unlock free products – as part of a wider SRH intervention – noticed that free **distribution of MH products was a hook to trigger regular visits to the program**: among the 34,116 visits made by the 6,374 young individuals, young women accessed pads, a cup or a reward linked to MH at 30% of visits[2]

Free MH product distribution can trigger access to SRH services, including FP — but additionality is uncertain

- In the CHIEDZA program, **MH services were the primary reason for visit but also allowed to get complementary SRH services[1]**
  - Out of participants coming for the first visit, 77.8% also took up **HIV testing**, 56.2% subscribed to **SRH sensitization by SMS** and 30.3% took up **contraception**
  - Yet, this study **did not determine the additionality** of such free distribution, i.e. whether it allowed to reach new people or whether it targeted menstruators that would have come anyway
- In the Yathu Yathu program, the intervention arm where comprehensive SRH services were provided saw an **increased uptake of contraceptives** (including condoms) **in the intervention arm compared to the control one[3].** Yet, this **did not lead to a decrease in birth rate, perhaps due to[4]:**
  - Hub closures during Covid and stock-outs in '20 and '21, potentially leading to discontinued use and loss of confidence in consistent availability
  - The existence of norms around pregnancy and fertility which Yathu Yathu was unlikely to change in such a short period
  - Potential trust issues that could arise with partners when suggesting to use condoms
  - A reflection of fertility desires and expectations

Source: [1] *Acceptability, uptake, and effectiveness of a menstrual health intervention among young women in Zimbabwe, PhD thesis, London School of Hygiene & Tropical Medicine*, Tembo (2023); *High uptake of menstrual 1 health information, products and analgesics within an integrated sexual reproductive health service for young people in Zimbabwe*, Tembo et al (2023); [2] *Access to menstrual hygiene products through incentivised, community-based, peer-led sexual and reproductive health services before and during the COVID-19 pandemic: findings from the Yathu Yathu trial*, Hensen et al. (2022); [3] *Interview with Yathu Yathu (2023);* [4] *The impact of community-based, peer-led sexual and reproductive health services on knowledge of HIV status among adolescents and young people aged 15 to 24 in Lusaka, Zambia: The Yathu Yathu cluster-randomised trial*, Bernadette et al (2023); Photo credits: Top left: *Chiedza study* (Mandikudza Tembo); Bottom left: *Yathu Yathu trial* (Bernadette et al)

Distribution of free MH products is likely to most impact MH indicators in places with limited MH product access and usage

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Distribution of MH products in trusted FP channels can facilitate access to MH products[1]

- In the Yathu Yathu program, adolescents shared that they were **more comfortable accessing pads in the hubs** set up by the program (considered as **private,** period-friendly **spaces**) rather than by visiting shops (that usually do not provide advice and where they can feel shy to ask for the products)
- As a result, **93.3% of adolescents in the Yathu Yathu arm had used a purpose-made menstrual product** at last menstruation, compared to **85% in the control group**

Yet, MH impact depends on pre-existing product availability, material quality as well as the quality of education and support provided for reusable MH products

★★☆

The Yathu Yathu evaluation showed that "*despite increased use of appropriate materials, we found* ***no evidence that Yathu Yathu had an impact on comfort of and satisfaction*** *with menstrual products*". **Lack of statistical evidence** of impact might reflect that:

1. Most menstruators were already using an appropriate material at last menstruation in the control zones[2]
2. Free disposable pads were non-branded, i.e., possibly perceived as of relatively poorer quality compared to branded pads

?

Given the initial high preference of disposable pads (as they are the most known products), **quality education and support** for both clients and service providers on MH reusable products is vital to drive adoption, as exemplified by CHW quotes[3]:

"… at first it was difficult to talk about the issue of the menstrual cup but now because I am using it and I have enough information, I can"

"I will liken educating clients about the cup as one preaching a sermon, and then you feel like this word is for me, but on your way home you meet a friend who then diverts you from what was preached... When a client goes home with [a cup] she will hear another set of information and will be convinced to not use the cup based on the advice at home"

Source: [1] *Access to menstrual hygiene products through incentivised, community-based, peer-led sexual and reproductive health services before and during the COVID-19 pandemic: findings from the Yathu Yathu trial,* Hensen et al. (2022)); [2] *Does distribution of menstrual products through community-based, peer-led sexual and reproductive health services increase use of appropriate menstrual products? Findings from the Yathu Yathu trial,* Bernadette et al (2023)[3] *Acceptability, uptake, and effectiveness of a menstrual health intervention among young women in Zimbabwe, PhD thesis, London School of Hygiene & Tropical Medicine*, Tembo (2023); Photo credits: *Yathu Yathu trial (*Bernadette et al)

Free distribution leads to additional complexity and costs, that improved SRH outcomes need to balance out

Cost efficiency of such programs remains uncertain

- **None of the programs** studied have measured cost-efficiency
- Researchers **explicitly state** the need to explore this further:

"A critical next step is to estimate the cost-effectiveness of the strategy and to implement and evaluate streamlined iterations of Yathu Yathu, with greater emphasis on linkage to services after HIV testing, in order to have a greater impact on the health and wellbeing of adolescent and young people"[1]

Adding distribution to education programs leads to increased cost and complexity

Compared to education only, **free distribution adds:**

- **Direct costs**, i.e., provision of free (good-quality) products, which negatively impacts the financial sustainability of programs
- **Time and effort** when[2]:
  - Explaining the use of new products, which required 10 to 15 additional minutes. In the case of cups, this required extensive health support over a longer period
  - **Screening out** ineligible women seeking MH products

In Nigeria, MSI team estimates that at scale, adding MH education and provision of free reusable pads would require adding approx. 20% to traditional outreach costs[3]

- **Procurement requirements:** The CHIEDZA program shows that **constant availability of products is essential**[2]**;** Stock-outs led some beneficiaries to **postpone their visit** to the center (waiting for them to be back in stock) **impacting the uptake** of the rest of the SRH services. Hence it is essential to find the right supply-chain partners and proactively invest in stock management practices

Thus, free product distribution is only justified if:

- Additional outcomes in terms of SRH service uptake > Added costs
- Donors are ready to pay for these additional outcomes. Adding specific funding to maximize MH outcomes is likely to be key to make these programs attractive to FP providers in the long-term

Source: [1] *The impact of community-based, peer-led sexual and reproductive health services on knowledge of HIV status among adolescents and young people aged 15 to 24 in Lusaka, Zambia: The Yathu Yathu cluster-randomised trial, Bernadette et al (2023)* [2] *Acceptability, uptake, and effectiveness of a menstrual health intervention among young women in Zimbabwe,* PhD thesis, London School of Hygiene & Tropical Medicine, Tembo (2023); [3] Interview with MSI (2023)

Model B

Opportunities for exploration: **Confirm the impact of free distribution of MH products on MH,FP and other SRH KPIs, explore key success factors, and scale where relevant**

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1 Quantify additionality of reach

How many additional, new persons have been brought to FP/other SRH services thanks to MH education and free MH product distribution? How does it compare to other efforts?

2 Measure uptake and continuation of FP and other SRH services and MH outcomes

- Does offering MH products increase the uptake and continuation of FP products/ SRH services compared to FP programs alone? Do menstruators feel compelled to use FP to access free MH products?
- Does offering MH products increase the number of menstruators being satisfied with their ability to manage their menstruation? Do menstruators continue to use the free MH products provided in the long term? What were they using previously? Does the share of menstruators reporting that menstrual period does not impact their day increase?
- Does offering a choice of different MH products increase uptake of FP/other SRH services and continuation to FP products compared to only one type of MH product? Does offering MH products increase the number of menstruators being satisfied with their ability to manage their menstruation?

3 Assess cost-effectiveness

What is the **cost of such programs at scale**, and how do they compare with alternate approaches to achieve similar outcomes? Do the additional SRH outcomes offset the added costs?

4 Identify key success factors

Which levers maximize their cost-effectiveness? This will require considering the following:

- **Staff training**: staff need to be trained on menstrual health, their link to SRH and on the various MH products to be able to provide effective, impartial information. Products distributed should ideally be tested by FP providers first to avoid biases toward certain products over others
- **Staff incentives**: it is likely FP providers will need to be incentivized on MH outcomes (product distribution) for programs to be effective. If programs offer a range of products, the incentive system should be differentiated by type of products given that reusable products, although more cost-effective over the long term for menstruators, typically require more support for adoption than disposable pads
- **Initial MH usage**: cost-effectiveness is likely to be higher in countries/ regions with low MH uptake and for young menstruators, who are usually the most reluctant to access FP centers due to cultural taboos

Source: Hystra analysis

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Model C – FP providers selling MH products commercially

Description

Selling both FP and MH products in the same distribution channel, with the objective to improve program sustainability and sales. Due to regulatory constraints, the most feasible approach to do so is to integrate the distribution of MH products into existing FP programs:

- Non-health channels selling MH products are less likely to sell FP products since they can technically only sell condoms due to health regulations
- Combined distribution is only likely to happen in private FP channels (that serve around 40% of FP users in the Global South with variations across countries[1]) due to requirements on payment capabilities and differences in supply chains
- This model includes distribution through pharmacies, shops of FP clinics, Community Health Workers, or online sales channels

Improved effectiveness potential on health outcomes?

Companies selling both FP and MH products **have not measured the effectiveness of combined sales in terms of SRH outcomes** compared to selling only one type of products, since they have in general mostly added MH products as an additional revenue opportunity (as opposed to a way to improve FP outcomes).

Improved cost-efficiency?

In theory, there is an **opportunity to generate additional revenues while leveraging existing infrastructure.** In practice**, it only works for MH products already in demand** (mostly disposable pads) **and/or in FP channels where prescribers have time to push new products** (see details on p.39-40).

Source: [1] *Who, What, Where: an analysis of private sector family planning provision in 57 low- and middle-income countries*, Campbell et al. (2015)

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Disposable pads can generate – marginal – additional revenues at minimal costs, depending on the type of providers

- **Combined sales leverage the same target customers**, enabling a potential increase in average basket size (e.g., in its programs supporting CHWs with training and products procurement, HANDS noticed that **48% of women buying sanitary napkins were also FP users)**
- The **attractiveness of additional revenues** generated by adding MH products **depends on the time FP providers have to promote new products and location:**

Low attractiveness → *High attractiveness*

FP clinics

- **Likely to be marginal,** especially in urban areas, since (1) clinics usually do not have idle capacities to sell new products, (2) women visit the clinics for FP specifically and usually not monthly, and (3) MH products are usually available elsewhere
- A few FP clinic networks have tried to, with **marginal sales**:
  - Marie Stopes Society Pakistan sells **3-4 pads per week** in a clinic (with around 70 weekly clients) through a vending machine, mostly as a backup for their clients
  - Greenstar tried to sell MH products in its clinics, but sold only around **6 packs per month** - while they have 200-300 monthly clients*.

Pharmacies

Potentially **more attractive** (if MH products are in demand) **since they:**

- Already sell a variety of health and hygiene products
- Are trusted channels
- Can easily add MH products thanks to their existing procurement systems and relatively more shelf space

Private CHWs

- Potentially also attractive for **some CHWs, who have more idle time** and for whom it can represent proportionally higher additional income
- They can also have **regular interactions** with clients, which helps in selling monthly recurring products like disposable pads
- For example, PSI Pakistan that implements a “business in a box model” for CHWs (providing them with products to sell in their communities, including FP and MH) noticed that CHWs earn an average PKR 2,000 per month, with **MH products representing 15% - 18% of their income**

* The reason healthcare providers share is that women receive menstrual health products as a package within delivery services and not as routine monthly products. Women are more comfortable buying from community educators on their door-to-door visits.

Source: Interviews with HANDS, MSS Pakistan, Greenstar, PSI Pakistan (2023)

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Net gains are more uncertain for reusable MH products, that require additional marketing and support to encourage uptake

The potential for additional revenues from reusable products is limited given the lack of recurring sales

- **Reusable products** are one-off products, competing with other products in demand generating recurring sales:
  - When Living Goods tried to sell reusable pads through CHWs, **only 5% of CHWs experienced repeat purchases,** with a price of $1-1.5 for a pack of two. This can be partly explained by the fact that CHWs had many competing priorities and were not incentivized to push these non-recurring and low-value products[1]
  - Womena, an NGO working in reproductive health, tried to sell menstrual cups through different channels including FP clinics and a network of 48 CHWs managed by MSI Uganda (MSIU):
    - Only **3 cups were sold in FP clinics while 318 cups were sold through CHWs**
    - They noticed that about half of the CHWs did not make any sales or restocked (these were mostly the older CHWs located in rural areas who were not personally convinced about the products). The remaining 50% managed to **sell 13 cups per active CHW on average**, at a maximum price of 7 USD [2]

The novelty of reusable products requires specific efforts to procure and sell them, which providers are not always able to do

- **Reusable products need advertising and counselling - that FP providers are not always able or best placed to provide**
  - AFRIpads tried selling reusable pads in FP clinics managed by MSIU but similarly to what has been observed with disposable pads in FP clinics, they soon realized that women go to clinics for specific treatments, and it is **not in their habits to buy pads there**
  - More generally, the **novelty** of reusable pads, the **limited shelf space** and the **lack of advertising/referral** from frontliners made sales even more difficult, leading to the discontinuation of the pilot by MSIU - due to limited results and strategic reorientation[3]
  - The Womena's examples suggests that CHWs are probably better placed than FP clinics to provide such counselling
- **They also need a reliable supply chain to ensure availability and affordability.** MSI's GAP project had to lower its sales target by 40% due to:
  - **A high market price** ($6-10 per reusable menstrual kit), deemed too expensive by many menstruators to buy them
  - **The small size and limited experience of companies** selling them, hindering the build of momentum around them[4]

Source: [1]Interview with Living Goods (2023); [2] *Menstrual cup market accessibility project (MCMAP) – Evaluation report*, Womena (2020); [3] Interview with AFRIpads (2023); [4] *Keeping Girls in School Through Improved Reproductive and Menstrual Health - Gap Endline Evaluation*, Karen Hobday (2021)

Model C

Opportunities for exploration: **Test holistic women health centers, leveraging FP-MH synergies for improved quality of care**

HYSTRA
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1

Test new, further integrated models transforming FP centers/CHWs into holistic providers for women's SRH

- **Models that have been tested so far have limited integration** to solely adding products to an existing portfolio, showing marginal additional revenues in best cases
- To maximize both impact and revenue generation, there may be an opportunity to **create a more women-centric solution**, pushing integration further **to transform FP centers and/or community health workers into holistic providers for women's SRH**. Indeed, broadening the scope of FP centers to include notably MH topics seems to increase the acceptability of such services, hence their reach, while helping address broader SRH issues
- This will require some **organizational changes** within donors' organizations to encourage joint, more holistic approaches and within FP providers that will need to adapt their incentives, capabilities, and systems (e.g., procurement, spatial set-up) to support this additional objective

2

Assess health outcomes and cost-efficiency

- Similar to model B, ideally, the additional health outcomes and cost-effectiveness should be assessed and compared to separate interventions
- These approaches are more likely to prove effective and should be tested in priority in countries with low MH product uptake, where frontliners have idle time, ideally with different types of MH products to provide women with real choice

Source: Hystra analysis

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Model D – Dual-function products

Description

Beyond the three models of integration already implemented, a fourth possible model could go one step further in integration **by tackling both MH and FP at the same time, through a unique solution**. These types of solutions have not yet been tested, but some projects are under development.

Hormonal contraceptives could be used to stop menstruation

- Some types of contraceptives **highly reduce or stop menstruation (i.e., amenorrhea)**, addressing both FP and MH needs. These include[1]:
  - Progesterone-only pills
  - Hormonal IUDs (stopping menstruation for about 50% of users after six months, reducing them for 25% of them)
  - Continuous use of patches and vaginal rings
  - Birth control shots (75% of users stop menstruating after a year)

Yet, experts note that the “unpredictability of a particular method's CIMC for a particular user limits how this can be promoted. In addition, reduced or paused bleeding is often mixed with or preceded by several months of spotting, which is typically not desired”.[2]

- **Willingness to trigger amenorrhea has not been studied at scale** in the Global South, but it seems to vary greatly: across studies, the percentage of women preferring never bleeding (vs. monthly or less regularly than monthly) ranged from 0% in Tunisia to 65% in Brazil[3]

Dual-purpose products would enable to both manage menstruations and act as a temporary contraceptive[4]

- Bfree, which sells reusable MH products, is currently developing a new “Bfree Duo” product that would **both act as a menstrual cup and as a cervical cap**
- This answers a need observed in the field: during their training on menstrual cups, **adolescents or trainers often ask if they can use the cup as a contraceptive** – and some even try to do so
- The Bfree Duo is still in the **prototype phase**, but would be an immediately reversible **method of contraception,** also allowing to manage menstruation

Source: [1] How to Stop Your Period With Birth Control, [2] Interview with Lucy Wilson (2024) [3] WebMD (2023); Menstrual Suppression, Buck et al. (2023); [4] Interview with Bfree; Photo credit: Bfree

Model D

Opportunities for exploration:
Support the development and test of dual-purpose products

1

For FP products already available that reduce or stop menstruations

- **Systematize the use of the NORMAL tools in both FP counselling and MH education sessions** to ensure all menstruators are aware of these solutions and their potential benefits on MH management
- **Support further research assessing the interest of low-income menstruators** from the Global South in using them, identifying potential barriers to do so and methods to overcome them

MOST EXPLORATORY - LONGER TIMELINE TO IMPACT

2

For products under development
(e.g., MH products acting as contraceptives)

- **Assess the full cost of developing and creating adoption for dual products** (behavior change costs are likely to represent the highest share of the required costs)
- **Fund R&D** to develop new dual-purpose products that answer menstruators' diverse requirements and lower their costs
- **Support clinical trials and acceptability tests** to assess both their effectiveness and interest of menstruators
- **If relevant - develop pilots** (including strong measurement, learning and evaluation components) to assess the most effective and cost-efficient (commercial) distribution channels for these products

Source: Hystra analysis

Appendix

Detailed methodology

List of programs studied under each model

This research is based on an extensive literature review…(1/2)

- *A Field Test of the NORMAL Job Aid With Community Health Workers in Kenya to Address Contraceptive-Induced Menstrual Changes*, Burke et al. (2023)
- *Addressing the gap: Integrating menstrual health into the broader SRHR discussion*, Lucy Wilson, Independent Consultant, Rising Outcomes (2019)
- *Effects of sanitary pad distribution and reproductive health education on upper primary school attendance and reproductive health knowledge and attitudes in Kenya: a cluster randomized controlled trial*, Karen et al (2021)
- *Inclusion of menstrual health in sexual and reproductive health and rights*, Philips-Howard et al. (2018)
- *Integrating Menstrual Health*, Haider (2023)
- *Integrating Menstrual Health and Sexual and Reproductive Health and Rights - Insights from and implications for India*, WaterAid and UNFPA (2022)
- International technical guidance on sexuality education, UNESCO (2018)
- *Menstrual Bleeding Changes Are NORMAL: Proposed Counseling Tool to Address Common Reasons for Non-Use and Discontinuation of Contraception*, Rademacher et al. (2018)
- *Menstruation and the Cycle of Poverty: A Cluster Quasi-Randomised Control Trial of Sanitary Pad and Puberty Education Provision in Uganda*, Montgomery et al. (2016)
- *Missed opportunities Menstruation Matters for Family Planning*, Hennegan, Tsui and Sommer (2019)
- *Seeking synergies: understanding the evidence that links menstrual health and sexual and reproductive health and rights*, Wilson et al. (2021)
- *Strengthening Integrated Approaches for Family Planning and Menstrual Health*, Hoppes et al. (2023)
- *Technical Brief on the Integration of Menstrual Health Into Sexual And Reproductive Health and Rights Policies and Programmes*, UNFPA (2021)
- *Technical brief for the Integration of Menstrual Health in SRHR*, PSI (2019)
- *The Intersections Between Contraception & Menstrual Health: An Annotated Bibliography*, FHI 360 (2021)
- *The Power of Integration*, Global Menstrual Collective (2023)
- *The Symposium for Menstrual Health and Hygiene in West and Central Africa*, UNFPA (2020)
- *There might be blood: a scoping review on women's responses to contraceptive-induced menstrual bleeding changes*, Polis et al. (2019)

We have reviewed **90+ documents for this research**

On the left are included **key technical briefs and research papers** reviewed

This research is based on an extensive literature review…(2/2)

- *A Participatory Fertility Awareness Intervention to Increase Family Planning Acceptability and Use*, FACT (2019)
- *Acceptability, uptake, and effectiveness of a menstrual health intervention among young women in Zimbabwe*, PhD thesis London School of Hygiene & Tropical Medicine, Tembo (2023)
- *Access to menstrual hygiene products through incentivized, community-based, peer-led sexual and reproductive health services before and during the COVID-19 pandemic: findings from the Yathu Yathu trial*, Hensen et al. (2022)
- *Adolescent Sexual Reproductive Health Rights in Disaster Prone Areas of Bangladesh*, MS Bangladesh (2018)
- *Does distribution of menstrual product through community-based, peer-led sexual and reproductive health services increase use of appropriate menstrual products? Findings from the Yathu Yathu trial*, Hensen et al. (2023)
- *Keeping Girls in School Through Improved Reproductive and Menstrual Health - Gap Endline Evaluation*, Karen Hobday (2021)
- *Menstrual cups and sanitary pads to reduce school attrition, and sexually transmitted and reproductive tract infections: a cluster randomised controlled feasibility study in rural Western Kenya*, Philips-Howard et al. (2016)
- *Menstrual cup market accessibility project (MCMAP) – Evaluation report*, Womena (2020)
- *Menstrual Health and Hygiene in Mozambique: Evidence of interventions that improve girls' full and equitable participation in society*, Be Girl (2020)
- *Menstrual Health Programming in Zimbabwe: Tackling Stigma to Improve Girls' Reproductive Health*, PSI (2018)
- *Menstrual Management in Angola: Effectiveness of providing quality menstrual products and educational workshops in Huambo, Huíla, Luanda, and Lunda Sul*, Be Girl (2021)
- *Menstrual product choice and uptake among young women in Zimbabwe: a pilot study*, Tembo et al (2020)
- *NIRAPOD End-line Evaluation Report*, Human Development Research Centre (2020)
- *Pragati: Proof of Concept Result*, USAID and FACT (2017)
- *Promoting Adolescent Reproductive Health The Power of in Uttarakhand and Uttar Pradesh, India*, Futures Group International (2012)

Among these 90+ documents, we have also reviewed **project briefs and evaluations of existing programs combining FP and MH** – on the left are included the key papers we used for this research

…and interviews with key expert and practitioners (1/2)

Name	Organization	Position
Sophia Grinvalds **Michelle Tjeenk Willink**	AFRIpads	Founder Head of Partnerships and Communications
Diana Sierra	Be Girl	Founder and CEO
Leisa Hirtz	Bfree	Founder and CEO
Pratibha Pandey	ChildFund India	Senior Specialist for Health
Marni Sommer	Columbia University Mailman School of Public Health	Professor
Afaq Shaikh **Hiba Anwar**	DKT International	Senior Marketing Manager Marketing Manager
Emily Hoppes	FHI 360	Senior Technical Officer
Amita Dhanu	FPAI	Deputy Director General
Karina Rios Michel **Caroline Wangeci**	Girl Effect	Chief Creative & Technology Officer Director, Evidence and Insights
Arundati Muralidharan	Global Menstrual Collective	Coordinator
Fawad Shamim	Greenstar	GM Programs and NBD
Dr. Muhammad Sarwat Mirza **Zulfiqar Sario**	HANDS	Senior Advisor Health and Research Senior Manager
Sadaf Naz	Her Ground	Founder and CEO
Ashish Mukherjee	IPE Global	Vice President, Social & Economic Empowerment
Lillian Bagala	Irise International	Regional Director
Stella Kanyerere	Living Goods	Deputy Country Manager
Dr. Farhana Ahmad	MSI Bangladesh	Director, External Relation and New Business Development

We have conducted interviews with **30+ experts of the sector** (researchers, practitioners, funders) **gathering their insights and experience** and testing our hypotheses with them

We warmly thank them for their time and involvement

…and interviews with key expert and practitioners (2/2)

Name	Organization	Position
Megan Elliot, Helen Blackholly Jennifer Gassner	MSI Reproductive Choices	COO, Technical Services Director, Marketing Director,
Michael Randriamanantena Dr. Jean-Pierre Manshande	MSI Madagascar	Deputy Commercial - Sales Director Independent Consultant
Ogechi Onuoha	MSI Nigeria	Director of programs
Asma Balal	Marie Stopes Society Pakistan	Country Director
Ben Bellows	Nivi	Co-Founder and Chief Business Officer
Odette Hekster	PSI Europe	Managing Director
Ayesha Leghari	PSI Pakistan	Country Director
Dr Anjum Rizvi	Rahnuma Family Planning Association of Pakistan	Director of Programs
Sarah Webb	Reproductive Health Supplies Coalition	Senior Technical Officer
Lucy Wilson	Rising Outcomes	Independent Consultant
Dr. Maria Carmen Punzi	Rotterdam School of Management, Erasmus University	PhD Researcher in Menstrual Health and Social Change
Tanya Mahajan	The Pad Project	Director of International Programs
Olanike Adedeji	UNFPA	FP Programming Specialist
Halima Lila	UNFPA	Regional Coordinator, African Coalition on Menstrual Health and Youth Participation
Therese Mahon	WaterAid	Regional Programme Manager South Asia
Nicole Dagher	WaterAid	Project Manager
Dr. Mandikudza Tembo	Reckitt Global Hygiene Institute and The Health Research Unit Zimbabwe	Postdoctoral Research Fellow and Public Engagement Lead and Social Scientist
Dr. Bernadette Hensen Mwelwa M. Phiri	/	Researchers for the Yathu Yathu project

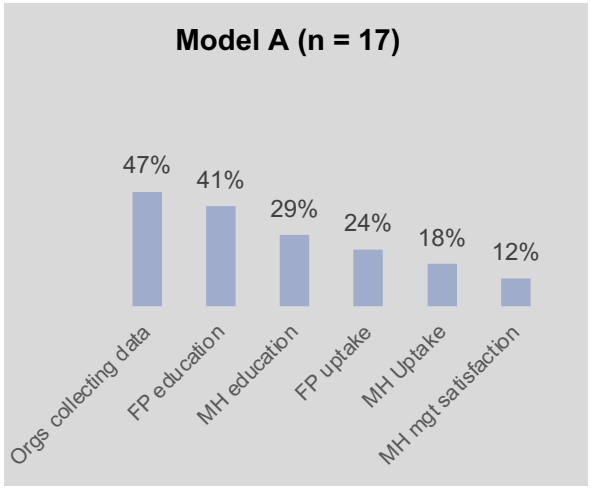
Appendix

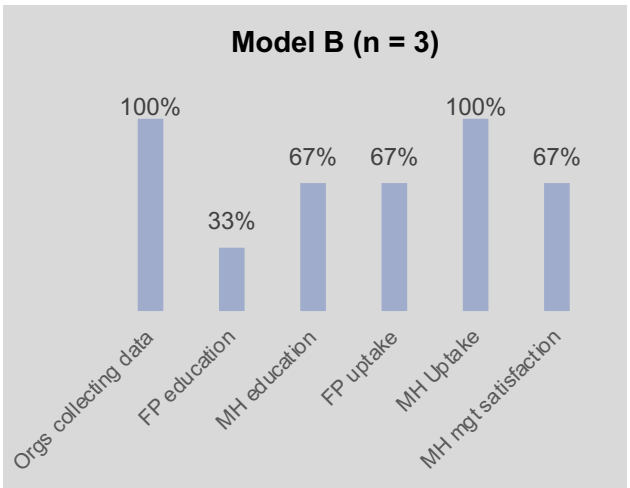
Detailed methodology

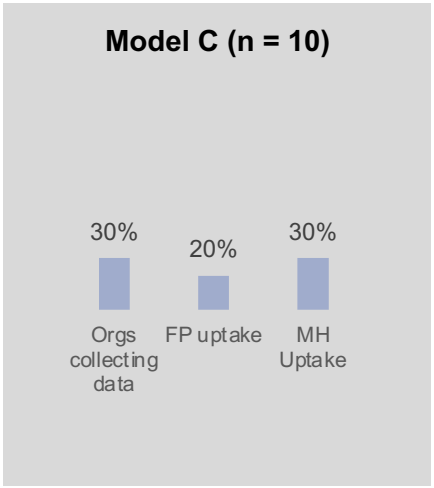
List of programs studied under each model

There is a wide variation in the collection rate of indicators between models

% of organizations in each model which collect indicators







- Only 47% of orgs in model A collect any indicator data
- Overall, there is a **higher data collection for FP indicators**, versus MH indicators that might be more complex to measure

All the organizations (n=3) collected data on **MH uptake**

Data collection is the **lowest among models** (30%), although this is a commercial model and data access **could be easier to get** from the point of sale (# products sold)

Model A – Combined education on both FP and MH (1/5)

Program name	Implementer	Country	Description and key results	Collection of indicators					
				Education		Product/ service uptake		FP continua-tion	MH mgmt satisfact-ion
				FP	MH	FP	MH		
ASRHR	MSI Bangladesh	Bangladesh	Launched in 2015 to help teachers discuss FP and MH. It included a new curriculum and flip charts for teachers covering SRH and MH. At program end, 92% of students were aware of contraceptive methods vs. 41% at baseline.	✓					
Business in a box model for CHWs	PSI	Pakistan	Procurement of products for CHWs to sell in their communities, including FP ones. Midway in the project, they started integrating MH into community sensitisation with women: to make conversations easier, they start by discussing MH rather than FP. PSI plans on extending the program to add MH products.						
Chhaa Jaa (India)	Girl Effect	Multiple	Online program created in 2019 to connect adolescent girls to information (e.g., video, social media) and services (e.g., helplines, connection to health professionals) to help them make informed decision about their futures, including SRH. So far, it has reached 23 million+ users in India.						
GAP	MSI / WaterAid	Timor-Leste, Papua New Guinea	Launched in 2017 to provide both MH and SRH/FP information in schools and to the community, also referring where to get related products, to address unintended pregnancy and menstrual health. 39,541 people improved their knowledge on SRH/FP and MH and, 8,742 started using a FP service.	✓	✓	✓	✓		

N:B: This project list is not exhaustive and was built thanks to desk research and interviews with sector experts and practitioners

Source: ASRHR final project report (2020); Girl Effect (2023); GAP endline evaluation (2021); Interviews with PSI, PSI Pakistan, MSI Bangladesh, and Girl Effect (2023)

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Model A – Combined education on both FP and MH (2/5)

Program name	Implementer	Country	Description and key results	Collection of indicators					
				Education		Product/ service uptake		FP continua-tion	MH mgmt satisfact-ion
				FP	MH	FP	MH		
GARIMA	ChildFund India	India	Conducted in 2017 to help adolescent girls and their immediate influencers (e.g., teachers, peers, communities) create positive social norms and healthy practices around MH. The program improved MH practices and knowledge on SRH and gender norms (e.g., 43.99% of girls had more positive MH management norms vs. 21.11% in the control group). More than 62 % adolescent girls reported menstrual hygiene or using sanitary napkins during menses. 60% of participants gained comprehensive and correct knowledge on SRH compared to 32% at baseline. Participants exposed to the intervention were 1.4 times more likely to have higher levels of discussion and dialogue related to menstruation and associated restriction, vs the control group.	✓	✓		✓		
HerWASH	WaterAid	Burkina Faso, Liberia, Sierra Leone, Pakistan	Launched in 2018 to empower the youth to access proper SRH and rights, with a specific focus on MH. Youth and Women champions facilitated training in schools, WASH committees and sparked conversations within communities (including men). The program also supported improvement in WASH infrastructures and in access to MH products.	?[1]					
My Body My Rules	PSI	Kenya	PSI distributes “My Body My Rules: A Girl’s Guide to Menstruation” brochures to young people to provide SRH information, using MH as an entry point for discussion						

[1] The project is currently under evaluation by independent consultants and the complete list of collected indicators is not available yet
N:B: This project list is not exhaustive and was built thanks to desk research and interviews with sector experts and practitioners
Source: UNFPA (2022); PSI (2018); Interviews with WaterAid, and ChildFund India (2023)

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Model A – Combined education on both FP and MH (3/5)

Program name	Implementer	Country	Description and key results	Collection of indicators					
				Education		Product/ service uptake		FP continua-tion	MH mgmt satisfact-ion
				FP	MH	FP	MH		
NIA project RCT	ZanaAfrica	Kenya	The study found that those participants in the sex education felt more positively about menstruation, knew more about sexual and reproductive health, had more equitable gender norms and were more self-confident at the end of the program. In one arm of the study, free disposable pads were also distributed. A comparison of estimates between intervention arms (combined v. pads only for menstruation outcomes; combined v. RH only for RH and norms outcomes) showed a larger effect size on RH attitudes in the combined arm as compared to the RH only arm	✓	✓		✓		✓
Pragati	Save the Children	Nepal	Pragati is a package of 9 interactive games designed to spark challenging conversations in communities on FP and social norms. It improved the environment for FP: participants to at least 4 games were 7.4 times more likely to have a high fertility awareness score. Family planning contraceptive usage increased from 31% at baseline to 35% at endline.	✓		✓			
Rashtriya Kishor Swasthya Karyakram (RKSK)	Indian Ministry of Health and Family Welfare	India	Comprehensive health program for adolescents launched in 2014, including but not limited to MH and SRH. Departing from the traditional clinic-based programs, RKSK reaches adolescents in their environments (e.g., communities, schools) to encourage them to visit adolescent friendly health clinics to address various SRH topics but also others like nutrition and substance abuse.						
Training of teachers with UNICEF	Family Planning Association of India (FPAI)	India	UNICEF-supported program to train teachers and girls on MH and SRH. 193 teachers and 132 frontline workers were trained to provide information on these topics, the teachers training being specifically focused on integrating MH into schools' curriculum.						

N:B: This project list is not exhaustive and was built thanks to desk research and interviews with sector experts and practitioners. Source: Effects of sanitary pad distribution and reproductive health education on upper primary school attendance and reproductive health knowledge and attitudes in Kenya: a cluster randomized controlled trial (2021); FACT (2019), Government of India (2023); Interview with FPAI (2023)

Model A – Combined education on both FP and MH (4/5)

Program name	Implementer	Country	Description and key results	Collection of indicators					
				Education		Product/ service uptake		FP continua-tion	MH mgmt satisfact-ion
				FP	MH	FP	MH		
Udaan	IPE	India	Created in 2017 In the Indian state of Rajasthan, to reduce teenage pregnancy by conducting education in schools (covering SRH and MH). The program helped avoid an estimated 2,795 pregnancies and exposure to the intervention improved contraceptive self-efficacy among boys (2.9 times vs control). Another component of the project reached first time injectable contraceptive users through a call centre to discuss CIMCs. Here the adherence to usage increased from 65% to 80%.	✓	✓	✓		✓	
/	Be Girl	Ghana, Mozambique and Kenya	Sells menstrual cups and reusable pads (500,000 products sold to date), including information on menstrual cycle and SRH in its attached training materials. Research conducted in Angola by Be Girl showed that attending a series of educational workshops on MH helped beneficiaries better understand the link between menstrual cycle and reproduction (39% before workshop vs 69% after it)	✓	✓				✓
/	Irise International	Kenya	NGO created in 2018 to provide education and access to MH. Their curriculum also includes FP since some of the students or beneficiaries are sexually active.						
/	Marie Stopes Society Pakistan	Pakistan	Health providers are trained on both FP and MH and can deliver dual counselling in clinics.						

N:B: This project list is not exhaustive and was built thanks to desk research and interviews with sector experts and practitioners

Source: IPE Udaan (Rajasthan) (2023); PSI (2020); Interviews with Be Girl, IPE, Irise International, MSS Pakistan (2023)

Model A – Combined education on both FP and MH (5/5)

Program name	Implementer	Country	Description and key results	Collection of indicators					
				Education		Product/ service uptake		FP continua-tion	MH mgmt satisfact-ion
				FP	MH	FP	MH		
/	Nivi	India, Kenya, Nigeria	The askNivi chatbot provides health advice through WhatsApp, with a focus on SRH health. Reaching 1.5 million users today, it has referred 20% of its users to 15,000 healthcare providers registered on the platform with different completion rates based on audience demographics, setting, and readiness (currently 4-8%). While the platform doesn't currently assess MH education outcomes, it could be easily implemented if donors' interest for such indicators was confirmed.			✓			
/	PSI	Latin America & Caribbean	PSI included MH as a key component of its SRH program for the youth aimed at reducing teenage pregnancies. The program includes both digital channels and delivery of care through providers, focusing on CIMCs and menstrual cycle to help girls better manage their cycles.						

N:B: This project list is not exhaustive and was built thanks to desk research and interviews with sector experts and practitioners

Source: Interviews with Nivi and PSI (2023)

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Model B – FP programs distributing free MH products

Program name	Implementer	Country	Description and key results	Collection of indicators					
				Education		Product/ service uptake		FP continuation	MH mgmt satisfaction
				FP	MH	FP	MH		
CHIEDZA	CHIEDZA healthcare providers	Zimbabwe	Research project (started in 2019) that set up centers combining MH and FP services for adolescents. Almost all female participants cited MHH as the first reason behind their initial visit. (**86.7%** took up the MHH intervention at first visit). Out of participants coming for the first visit, visitors also **took up other services** like SRH sensitization by SMS (56.5%) and contraception (30.3%). After the intervention, participants were 12.14 times more likely to have correct responses for MH knowledge. After the intervention, participants reported feeling more confident about knowing how to manage their menstruation using reusable products. 14.2% participants had given correct responses to reusable pads usage practices before the intervention, versus 34.4% a year later. Corresponding figures for cups were 21.1% and 48.5% respectively.	✓	✓	✓	✓		✓
Yathu Yathu	Peer support workers	Zambia	Cluster randomised trial (RCT) started in 2010 to estimate the impact of community-based, peer-led SRH services for young adults. They could access FP and MH education and products, getting reward points when accessing these services, that could be used to "buy" hygiene products. 93.3% of respondents noted use of a purpose-made MH product at last menstruation, vs control group which was at 85.7%. In terms of condom use at last sex and met need of contraceptives among sexually active people, there was little difference between the intervention and control groups. (i.e. 40.4% intervention vs 41.5% control for condom usage, and 60.1% intervention and 59.7% control for contraceptives)			✓	✓		
Messengers of Hope	Family Planning Association of India	India	Started in 2019 to improve SRH and MH for women in slums over 4 months, it includes health check-up sessions, education and product distribution and led to improvements in general health including MH (e.g., 90% were comfortable using pads vs. 62% before). Before the intervention, 17 girls agreed to have remained absent from school due to pain and discomfort, but after the intervention, this fell to 5 after they were asked to practise healthy eating and living. 22 girls complained about irregular period flow before the intervention, and 15 after it.		✓		✓		✓

N:B: This project list is not exhaustive and was built thanks to desk research and interviews with sector experts and practitioners

Source: Tembo et al. (2023); Hensen et al. (2022); Interview with FPAI (2023); FPAI website

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Model C – FP providers selling MH products commercially (1/2)

Program name	Implementer	Country	Description and key results	Collection of indicators					
				Education		Product/ service uptake		FP continua-tion	MH mgmt satisfact-ion
				FP	MH	FP	MH		
GAP	MSI / WaterAid	Timor-Leste, Papua New Guinea	Within the GAP program, MSI conducted supply chain development activities with women entrepreneurs to support sales of reusable menstrual products. Only 1,465 locally produced products were sold (vs. an objective of 2,900) due to affordability and procurement challenges and the low experience of companies. This model belongs to both model A and C as it has a separate education and product distribution arm.				✓		
Marvi workers	HANDS	Pakistan	HANDS created a network of CHWs called "Marvi workers" and supports them in creating "Marvi centers" where they deliver FP counselling sessions, screen for some diseases and sell health and hygiene products. 53% of married women in their areas adopted FP thanks to their services, compared to 20-25% of women purchasing MH products.			✓	✓		
NIRAPOD	MSI Bangladesh	Bangladesh	In addition to offering FP education sessions, the project aimed at supporting marginalized women from local communities to become entrepreneurs and sell hygiene products, including FP and MH. 693 women were running such shops in 2019.						
/	Family Planning Association of India	India	The FPAI sells disposable pads and FP products (condoms, OC pills, IUD) at cost price in their clinics and through their networks of CHWs.						
/	Living Goods	Kenya, Uganda	CHWs networks selling health and hygiene products while delivering counselling, including on FP and MH. Project now suspended because of a strategic pivot.			✓	✓		

N:B: This project list is not exhaustive and was built thanks to desk research and interviews with sector experts and practitioners

Source: Interviews with HANDS Pakistan, MSI Bangladesh, Family Planning Association of India and Living Goods (2023); GAP endline evaluation (2021)

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Model C – FP providers selling MH products commercially (2/2)

Implementer	Country	Description and key results	Collection of indicators					
			Education		Product/ service uptake		FP continua-tion	MH mgmt satisfact-ion
			FP	MH	FP	MH		
AFRIpads	Uganda	Reusable pads brand that tried selling in two FP channels: reproductive health clinics and pharmacies of MSI Uganda (now discontinued), and CHWs networks.						
Greenstar	Pakistan	On top of its FP activities, Greenstar piloted selling MH products in its FP clinics in 2021, now having paused them due to low sales.						
Kasha	Kenya, Rwanda	Online platform selling MH products, providing contraceptive consultations (allowing for appointments in dedicated clinics and method comparison) and selling condoms and emergency pills.						
MSI Madagascar	Madagascar	To increase access to MH products, MSI Madagascar has started acting as a supplier for their distribution, selling to healthcare facilities and shops. 99% of the sales in Madagascar are made to wholesalers and grocers, and only 1% is sold directly to clients via health workers.						
SMC	Bangladesh	Social marketing enterprise selling both disposable pads and contraceptive methods (condoms, pills, implants and IUDs) through 550,000 retail stores, 110,000 pharmacies, and a network of 12,000 wholesalers.						

N:B: This project list is not exhaustive and was built thanks to desk research and interviews with sector experts and practitioners

Source: Interviews with MS Madagascar, AFRIpads, Greenstar, SMC (2022-2023) and websites

Model D – Dual function products

Company	Country	Description and key results	Collection of indicators					
			Education		Product/ service uptake		FP continua-tion	MH mgmt satisfact-ion
			FP	MH	FP	MH		
Bfree	Global	Sells menstrual cups and is developing a menstrual cup which is also a cervical cap.						

N:B: This project list is not exhaustive and was built thanks to desk research and interviews with sector experts and practitioners

Source: Interview with Bfree (2023) and website

For more details and further discussion, please reach out!

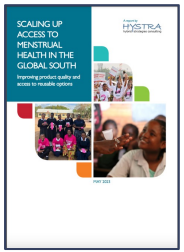
This document was prepared by Hystra with support from the Bill & Melinda Gates Foundation

Hystra is a strategy consulting firm specialized in inclusive business, whose mission is to scale innovative market-based approaches addressing critical social and environmental challenges in the Global South, with a focus on low-income populations – more about Hystra here

For more information on this research
or if you are interested in developing and piloting programs combining menstrual health and family planning, please reach out to:

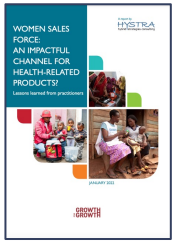
Lucie Klarsfeld McGrath, Partner – lklarsfeld@hystra.com
Jeanne Charbit Dunoyer, Project Manager – jcharbit@hystra.com

To learn more on improving access to health products and services in the Global South, you can refer to previous Hystra reports, available on our website:



Scaling Up Access to Menstrual Health in the Global South

Scaling Up Inclusive Healthcare in Low- and Middle-Income Countries



Women sales force: an impactful channel for health-related products?

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Thank you